## SAFE CARE

#### Introduction

Confronted with a hospital that routinely recorded a patient fall daily and staff perceptions that falls were routine, abysmal hand hygiene, narcotic diversions, and skyrocketing CLBSIs coupled with alarming NDNQI results, the CNO stopped the line.

The CNO and nursing leaders with frontline nurses implemented a comprehensive SAFE CARE culture, transforming care across 18 units in 8 weeks to create the synergy that resulted in sweeping changes at the frontline.

### Implementation

Safety First: Focus Leadership AND Frontline on Patient Safety

Awareness: Achieving with data best practice outcomes for every patient

Focus: Real Time "performance improvement"

**Expectations:** Exceptional CARE for every patient

**Communication:** Clear leadership expectations for JUST CULTURE

Accountability: Action to Active SAFE CARE

**R**ecognition: Recognize/Share Innovations....Success across all Units

**E**xcellence: Empowering Frontline to TRANSFORM CARE





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# NOW "Lead" this: SAFE CARE Creating a Culture of Safety

Vigilance, Discipline, Inspire.....Zero defects is an obtainable goal

- Safety Coach Program
- Shared Governance
- Action Plans that close the GAP

### Sustain the Gain

## Recognition of Opportunities

Culture

Of

Safety

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#### Education

Knowledge transfer to empowe safe care

- Simulation
- Just Culture
- Online modules
- Team STEPPS

### Equipment & Resources

Determine gaps and Address

- Right Supplies at the right time
- Safe patient handling program
- Smart coaches

### Patient/Family Engagement

#### Respect, Partnership, Collaboration. working together





Awareness, Learning, adaptability.. learning from ALL incidents • Scorecards

- NDNQI benchmark for quality outcomes ie: falls
- NDNQI benchmark for staff satisfaction and engagement
- AHRQ Survey for safety
- Event reporting systems

### Leadership Engagement

- Vigilance, Empowermer Accountabili ..leading b example
- Just Culture
- Unsafe Acts algorithm
- Cx of Safety Steering Team
- Leadership reviews of incidents weekly

#### Communication.

- Awareness learning adaptabil ...safety lives in conversatio
- Debriefings after inc
- Safety Huddles
- Cx of Safety Unit Bo
- Leadership 24/7/365 alerts
- for incidents
- Safety Alerts "Let's Talk" Staff Rounds

### Performance

### Improvement

- Care Boards
- Hourly rounding
- Patient Advisory councils
- Care Partners

Empowerment Accountability. Adaptability. we can change things

- Real Time PI
- Debriefings
- Peer Reviews
- Root Cause Analysis

Progress over Perfection

### Discussion

**SAFE CARE is not about tasks** 

**Accountably to create SAFE CARE increases with the** pressure of Transparency

Sharing days "since last fall" openly brings PRIDE

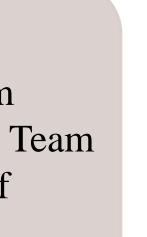
Changing a culture takes focus, endurance, empowerment, and leadership support It takes PASSION even when you have nothing left to give...

Patients and families provide insight

### Results

- 50% reduction falls and falls with injuries
- 50% improvement in units achieving NDNQI mean
- •45% improvement hand hygiene
- Reduced CLBSI rate by 36%
- Reduced staff narcotic diversions
- NDNQI RN satisfaction 10 /10 domains improved with 100% above mean
- Reduced restraint utilization by 30% with 50% improvement perfect documentation

Progress Towards Perfection



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